SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.

This is a summary of benefits for your Base/Major Medical plan.

BorgWarner, Inc.
Pesco Hourly Medicare Retirees- BM2
Base/Major Medical Plan
Effective 1/1/2019

BENEFIT HIGHLIGHTS	BASE PLAN	MAJOR MEDICAL PLAN
PPACA Status	Exempt	
MH/SUD Parity Status	Exempt	
Lifetime Maximum	Not Applicable	Does Not Apply
Coordination of Benefit Administration	Non-Duplication	
Coinsurance Levels	100% of the Maximum Reimbursable Charge (AKA Reasonable and Customary)	80% of the Maximum Reimbursable Charge (AKA Reasonable and Customary)
Maximum Reimbursable Charge Determined based on the lesser of: •The provider's normal charge for a similar service or supply or •A percentile of charges made by providers of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. Note: The provider may bill the customer the difference between the provider's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments, and coinsurance.	90th percentile	90th percentile
Calendar Year Deductible *Individual* *Family Maximum* *Aggregate*	Not Applicable	 $50 per person Not Applicable Not Applicable
Annual Out-of-Pocket Maximum *Includes Deductible* *Individual* *Family Maximum* *Aggregate*	Not Applicable	Unlimited

BENEFIT HIGHLIGHTS	BASE PLAN	MAJOR MEDICAL PLAN
Physician's Services		
Primary Care Physician's Office visit *Specialty Care Physician's Office Visit* **Note:** OB/GYN is considered a Specialist *Per visit allowable is benefit payable - it is not a copay; there is no deductible applied before allowable*	If follow-up to injury or illness where hospitalized, then allow $5/visit, if at physician's office during daytime; allow $7.50/visit, if daytime home visit; allow $15/visit, if home visit is between 11pm & 8am	Not Covered
Surgery Performed In the Physician's Office	100% up to $800 max/surgery	Not Covered
Allergy Treatment/Injections	Not Applicable	Not Covered
Preventive Care *Routine Preventive Care for children through age 2 (including immunization)*	Not Applicable	Not Covered
PSA, Pap Smear	Not Applicable	Not Covered
Routine Mammograms	Not Applicable	Not Covered
Outpatient Pre-Admission Testing *Primary Care Physician's Office Visit* *Specialist Physician's Office Visit* *Outpatient Facility*	 Not Covered Not Covered 100% up to $100/yr x-ray/lab max	 Not Covered Not Covered Not Covered
Inpatient Hospital - Facility Services *Semi-Private/PrivateRoom* *Intensive Care Unit* *Necessary Services and Supplies (Hospital Extras Maximum)*	365 days maximum per calendar year 100% 100% Unlimited	Not Covered Not Covered Not Covered Not Covered
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room*	100%	Not Covered
Inpatient Hospital Physician's Visits/Consultations	Allow $5/day up to 365 visits/yr	Not Covered
Inpatient Hospital Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	Surgery 100% up to $800 max/surgery; 100% up to $100 x-ray/lab max; 100% up to $100 x-ray/lab max 100% of schedule = $20 for 1st hour; $10 for each of the next two 15 minute periods, then $5 for each remaining 15 minute period.	Not Covered
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	

BENEFIT HIGHLIGHTS	BASE PLAN	MAJOR MEDICAL PLAN
Outpatient Professional Services		Not Covered
Surgeon	Surgery 100% up to $800 max/surgery	
Radiologist	100% up to $100 x-ray/lab max	
Pathologist	100% up to $100 x-ray/lab max	
Anesthesiologist	100% of schedule = $20 for 1st hour; $10 for each of the next two 15 minute periods, then $5 for each remaining 15 minute period.	
Emergency and Urgent Care Services		
Physician's Office	100% up to $800 if surgery performed; allow $5/visit if due to medical emergency/accidental injury, also allow $5/visit applies if treated anywhere other than Hosp. ER	Not Covered
Per visit allowable is benefit payable - it is not a copay; there is no deductible applied before allowable		
Hospital Emergency Room	Allow $15/visit if due to medical emergency/accidental injury; otherwise not covered	Not Covered
Urgent Care Facility or Outpatient Facility	Allow $5 if due to medical emergency/accidental injury; otherwise not covered	Not Covered
Ambulance	100%	Not Covered
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities*	100% up to 120 days, then additional days to MM	Thereafter, 80% no deductible, up to 245 days
Laboratory and Radiology Services	100% Up to $100/calendar yr	Thereafter, 80% after deductible
MRIs, CAT Scans and PET Scans		
Other Laboratory and Radiology Services (All charges billed by independent facility)		
Diagnostic Lab & X-ray combined calendar year maximum	Up to $100/calendar yr Combined max for diagnostic & independent services	Thereafter, 80% after deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services Unlimited maximum per calendar year --Includes: Physical Therapy	100% only	Not Covered
Cardiac, Speech, Occupational, & Chiro are Not Covered		
Radiation Therapy	100%	Not Covered
Chemotherapy	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	BASE PLAN	MAJOR MEDICAL PLAN
Home Health Care **Note:** The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).	Not Covered	Not Covered
Outpatient Private Duty Nursing	Not Covered	80%; maximum 240 visits/yr
Hospice *Inpatient Services* *Outpatient Services*	 Not Applicable Not Applicable	 Not Covered Not Covered
Bereavement Counseling *Services provided as part of Hospice Care Inpatient & Outpatient*	Not Applicable	Not Covered
Maternity Care Services *Initial Visit to Confirm Pregnancy* *All Subsequent Prenatal Visits, Postnatal Visits, and Delivery* *Delivery (Inpatient Hospital, Birthing Center)*	 Not Applicable 100% up to $800/surgery max 100% same as any other inpatient confinement	 Not Covered
Abortion Services *Includes therapeutic (non-elective) procedures only*	100% up to $800/surgery max. Coverage only if life of mother is endangered	Not Covered
Family Planning Services *Office Visits (tests, counseling)* *Surgical Sterilization* Procedure *for Vasectomy/Tubal Ligation (excludes reversals)*	Not Applicable	Not Covered
Infertility Treatment *Services not covered include:* • *Testing performed specifically to determine the cause of infertility.* • *Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).* • *Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).* *Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*	Not Applicable	Not Covered

BENEFIT HIGHLIGHTS	BASE PLAN	MAJOR MEDICAL PLAN
Organ Transplant *Includes all medically appropriate, non-experimental transplants. LifeSource does not apply* *Office Visit* *Inpatient Facility* *Physician's Services*	 Not Applicable 100% same as other hospitalization 100% up to $800 max/surg.	 Not Covered Not Covered Not Covered
Durable Medical Equipment Unlimited maximum per calendar year	Not Applicable	Not Covered
External Prosthetic Appliances Unlimited maximum per calendar year	Not Applicable	Not Covered
Dental Care *Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.*	Not Applicable	Not Covered
TMJ	Not Applicable	Not Covered
Oral Surgery	100% up to $800max/surgery	Not Covered
Routine Foot Disorders	Not Applicable	Not Covered
Mental Health and Substance Abuse *Inpatient Mental Health* *Inpatient Substance Abuse* 365 days maximum per calendar year *Outpatient Mental Health* *Includes Individual, Group and Intensive Outpatient* *Physician's Office* *Outpatient Facility* *Outpatient Substance Abuse* *Includes Individual and Intensive Outpatient* *Physician's Office* *Outpatient Facility*	 100% 100% If follow-up to injury or illness where hospitalized, then allow $5/visit, if at physician's office during daytime 100% If follow-up to injury or illness where hospitalized, then allow $5/visit, if at physician's office during daytime 100%	 Not Covered Not Covered
Pre-existing Condition Limitation (PCL)	Does Not Apply	
Pre-Admission Certification - Continued Stay Review.	Does Not Apply	
Case Management	Does Not Apply	
Prescription Drugs	Not Applicable	Not Covered

Medical Benefit Exclusions *(by way of example but not limited to):*

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the " Clinical Trials" section of "Covered Services and Supplies."
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of non-surgical TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
13. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
15. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.

19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
20. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
21. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
22. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services," or "Breast Reconstruction and Breast Prostheses" sections of the "Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Covered Services and Supplies."
24. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
25. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
26. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
27. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. Treatment by acupuncture.
31. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies."
32. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
34. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
35. Dental implants for any condition.
36. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
39. Cosmetics, dietary supplements and health and beauty aids.
40. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
41. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
42. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.

43. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
44. Telephone, e-mail & Internet consultations and telemedicine.
45. Massage Therapy

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, see your employer's summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.